FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uninsured, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA's quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Prepared by
Doug Skarr

Data Analysis by
Sina Shaahinfar

Technical support by
Suzanne Larez

To request copies of this report, please call the Managed Risk Medical Insurance Board at (916) 324-4695 or view the Managed Risk Medical Insurance Board website at www.mrmib.ca.gov.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory **CALIFORNIA**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name (s) **HEALTHY FAMILIES/MEDI-CAL FOR CHILDREN**

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
_x_ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

Contact Person/Title **Doug Skarr/Research Program Specialist II**

Address **Managed Risk Medical Insurance Board**
1000 G Street, Suite 450
Sacramento, California 95814

Phone **(916) 324-7444** Fax **(916) 324-4878**

Email **Dskarr@mrmib.ca.gov**

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program's changes and progress during the Federal fiscal year 2000 (September 30, 1999 to October 2000.)

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: ***If no new policies or procedures have been implemented since September 30, 1999, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.***

1. Program eligibility

California changed the income eligibility criterion for the Healthy Families Program to extend coverage to children in families with incomes up to 250 percent of the federal poverty level (fpl). This change was effective November 1999. The number of children enrolled in the HFP from December 1, 1999 to September 30, 2000, whose family income was between 200 percent to 250 percent of fpl was **42,523**.

2. Enrollment process

To simplify the enrollment process for families who have existing children enrolled in the Healthy Families Program, California developed a new form, ***Add A Child***. This form prevents duplicate cases and simplifies the application process. This form can also be forwarded to the county for possible Medi-Cal eligibility.

3. Presumptive eligibility

NC. The Healthy Families Program does not use presumptive eligibility.

4. Continuous eligibility

NC. Children are enrolled in Healthy Families for a continuous 12-month period. Children enrolled in Medi-Cal for Children (MCC) during the 1999/00 federal fiscal year were continuously enrolled for three months. Beginning January 1, 2001, children enrolled in MCC will be provided 12 months of continuous eligibility.

5. Outreach/marketing campaign

The school outreach program was expanded and modified to identify and enlist key education-associated organizations throughout California to promote the HFP to children through these membership organizations.

6. Eligibility determination process

NC. See Appendix

7. Eligibility redetermination process

N/C. See Appendix

8. Benefit structure

California recently enacted a mental health parity law that requires all managed care plans to cover serious mental illness and children who are seriously emotionally disturbed. As a result, managed care plans that provide services to the Healthy Families Program were required to expand their mental health benefits.

As of July 1, 2000, all managed care health plans must offer inpatient services, partial hospitalization, intensive outpatient and outpatient services to patients who are diagnosed with one of seven serious mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulima nervosa.

These services are covered without a limit on the cost or number of days provided during each benefit year. Subscribers are informed of this new benefit through each health plan's Evidence of Coverage booklet and through the HFP handbook.

9. Cost-sharing policies

The exemption from cost sharing (premiums and co-payments) for American Indian descendants and Native Alaskan was implemented during the September 30, 1999 through October 1, 2000 federal fiscal year. Subscribers qualify for this exemption when the applicant provides one of three certification documents:

- American Indian or Native Alaskan enrollment document from a federally recognized tribe
- Certificate of Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs
- Letter of Indian Heritage from an Indian Health Services facility operating in California

Once the program receives the required certification, invoices for premiums are suspended. Health, dental and vision plans are also notified so they can instruct their providers to refrain from collecting copayments from subscribers who have demonstrated that they meet the criteria for a cost-sharing exemption.

Letters were mailed to all families where there was an indication on the application that a child in the household was American Indian or Alaskan Native. As of September 30, 2000, 326 American Indian/Alaskan Native children had been granted the cost-sharing exemption. The joint HFP/MCC application was modified to assure that applicant families are aware of the exemption.

The implementation process was developed with the advice from the California Rural Indian Health Board.

10. Crowd-out policies

NC. The Healthy Families Program continued to exclude children from enrollment if they have had employer-based coverage less than 90 days from the day of their application.

11. Delivery system

On July 1, 2000, two health plans were added to the HFP. One of the two health plans covers several rural counties, thus increasing the number of subscribers having a choice of at least two plans throughout the state. As of September 30, 2000, **99.9%** of subscribers had a choice of at least two health plans. This is higher than the percentage reported in the State Evaluation and Annual Report for FFY 1999.

In addition to the changes in health plan offerings, a new dental plan was introduced. This plan provided additional choice to families in 3 southern California counties.

12. Coordination with other programs (especially private insurance and Medicaid)

NC. See Appendix.

13. Screen and enroll process

NC. California uses a Single Point of Entry to screen and enroll children in the Healthy Families Program and Medi-Cal for Children.

14. Application

NC.

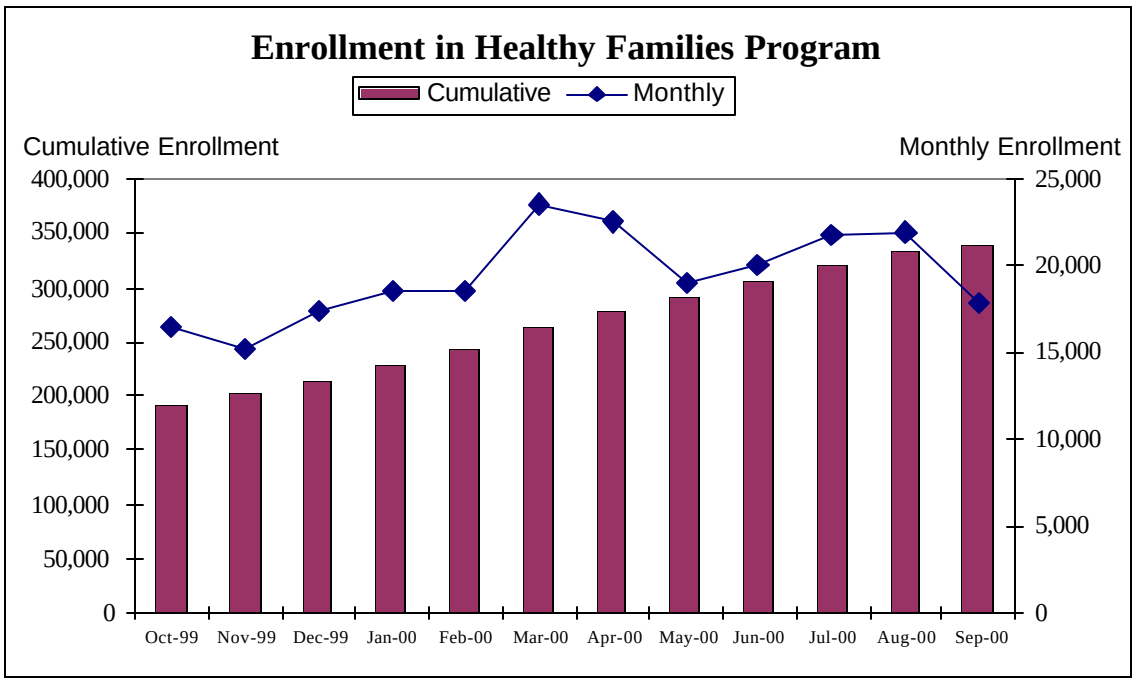
15. Other

NC.

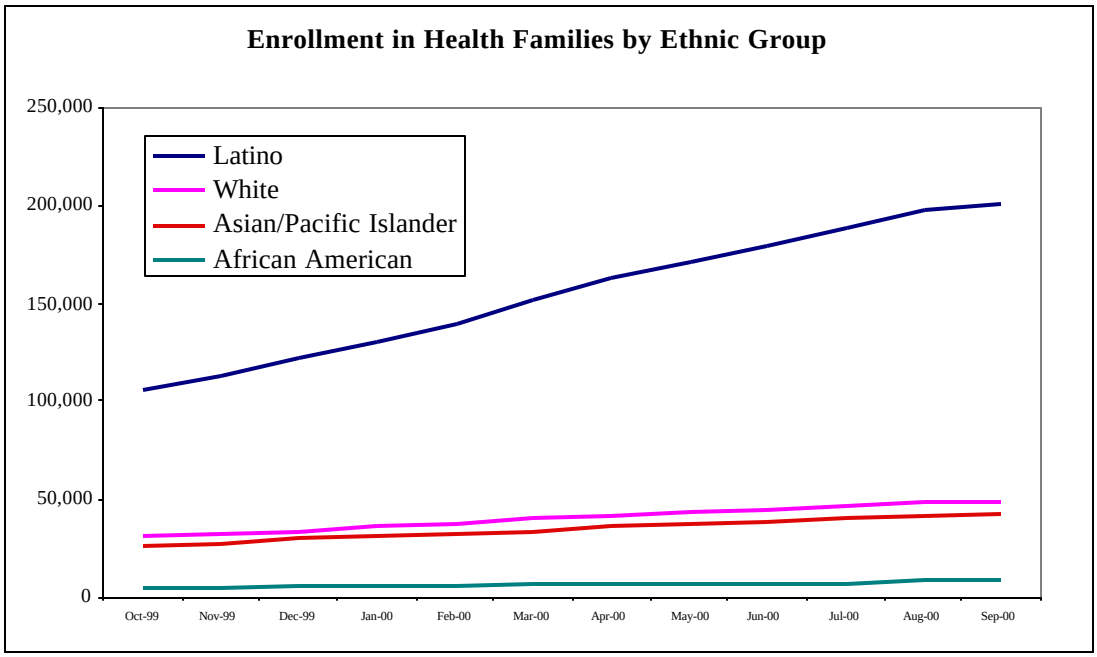
1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. ***Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.***

The enrollment in the Healthy Families Program grew from 176,031 as of September 30, 1999, to 331,507 as of September 30, 2000. This represents an 88% increase in total enrollment during the period. The total number of children ever enrolled increased to 403,955. On average, 19,391 children were enrolled each month during FFY 2000.



The program experienced the most growth in the Latino population, which continued to comprise the majority of enrollment, 67% of the enrolled base.



2. ***How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.***

The Healthy Families Program and MCC screening process is conducted through a "Single Point of Entry" (SPE) process. All applications for the Healthy Families Program/Medi-Cal for Children are mailed to this central location where they are initially screened for Medicaid income eligibility. During FFY 2000, 37% of applications received at the SPE were forwarded to the Medi-Cal.

The Healthy Families/Medi-Cal for Children outreach campaign includes both a call to action using the 888 747-1222 toll free number and local, community based outreach efforts to increase the number of children enrolled in Medi-Cal and Healthy Families. The number of children enrolled in Medi-Cal is a result of these efforts as well as families enrolling in the Section 1931(b) program as a result of county outreach efforts funded through the State. If the parents are not eligible for Section 1931(b), the children are evaluated for the 100, 133 or 200 percent programs, depending on their ages. The combined effect of these outreach efforts, as well as simplification of the Medi-Cal enrollment process, has been an increase in the number of children enrolled in the Medicaid Expansion and One Month Bridge programs, notwithstanding a slight decrease in the total number of children enrolled in the Medi-Cal program. As of June 2000, 20,827 children were enrolled in Medicaid Expansion program and 2,946 in the One Month Bridge. (See detail on page 15.)

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The Healthy Families enrollment growth, coupled with the number of children having been enrolled in Medi-Cal as a result of SCHIP outreach activities, provide the best evidence of the progress that is being made in California towards reducing the number of uninsured, low income children in the state.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

_____ No, skip to 1.3
__X__ Yes, what is the new baseline?

639,000

What are the data source(s) and methodology used to make this estimate?

1999 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found on the UCLA Website at : www.healthpolicy.ucla.edu/publication.html

What was the justification for adopting a different methodology*?*

The methodology used for estimating the baseline did not change. The change in the baseline estimate is the result of updated information regarding the uninsured that was included in the 1999 CPS along with the incremental expansion of the target population included in the 200%-250% of FPL category.

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

UCLA Center recommends the estimate be viewed as an approximation for two reasons:

1.) The CPS sample sizes of uninsured children in these subgroups are small, and consequently, result in unstable and imprecise estimates; and

2.) The CPS does not ask respondents whether they are documented or undocumented immigrants. The UCLA Center, therefore, modeled documentation status in order to exclude from the estimates those children who would be ineligible for any public coverage other than emergency Medi-Cal services.

The CPS is widely believed to undercount Medicaid enrollment and therefore overstate the number of uninsured children. The Urban Institute's TRIM2 model attempts to adjust for the Medicaid undercount by aligning Medicaid enrollment on the CPS to HCFA administration data. The adjustment imputes enrollment having been to individuals meeting Medicaid eligibility criteria to match HCFA's estimates of individuals ever on the Medicaid program at any time during the year. This is consistent with the way the CPS poses questions about insurance coverage. It will overstate the number of Medicaid and understate the uninsured at a point in time. The number of children who are eligible for Medicaid as well as the number of uninsured at any point in time probably lies between the CPS and the Urban Institute's estimates.

Over the period, estimates of the baseline target of uninsured have increased from 328,000 to 639,000. This doubling from the prior year was mostly due to eligibility changes that raised the income level to 250% of fpl (+211,000) and a general demographic increase of +100,000 based on estimates using the CPS. As discussed in the above section, the CPS is widely believed to undercount Medicaid enrollment and therefore overstate the number of uninsured children. The UCLA study has cautioned that the total estimate be viewed as a range and not an absolute value.

With this in mind, it is appropriate to display the HFP progress in reducing the number of uninsured children by reviewing changes from 1999 in both the estimates and the actual subscriber growth.

100% to 200% of FPL

Measure	1999	2000	% Change
Target Population	328,000	428,000	+30%
HFP Enrollment	176,031	288,984	+64%

The above table shows both the significant upward revisions in the UCLA estimate (+30%) and the progress of the HFP in reducing the number of uninsured (+64%) during the same period. It also illustrates that the HFP current enrollment of 288,984 in the 100%-200% category is 88% of the 1999 estimate, prior to the eligibility change to 250% of fpl.

200% to 250% of FPL

The HFP enrolled 42,523 subscribers in the 200% to 250% of fpl population during the FFY 2000 reporting period. UCLA has estimated that the total uninsured in this population is 211,000. Using these estimates, the HFP achieved a 20% penetration for this target population during the reporting period.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

If the baseline had not changed, California would have achieved an 88% penetration of the prior year's original baseline estimate of **328,000.**

1.3 ***Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).***

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: ***List your State's strategic objectives for your SCHIP program, as specified in your State Plan.***

Column 2: ***List the performance goals for each strategic objective.***

Column 3: ***For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary***.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter NC (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1.3.1 Increase Awareness	1.3.1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	Data Sources: CA Department of Health Services Methodology: Analyze changes in number of eligible children in Medicaid in FFY 1999 and FFY 2000. Progress Summary: See narrative on page 16.
	1.3.1.2 Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	Data Sources: CA Department of Health Services and "State of Health Insurance in California, 1999" Schauffler UC Berkeley/Brown UCLA 2000 Methodology: Analyze changes in number of eligible uninsured children from FFY 1999 to FFY 2000. Progress Summary: See narrative on page 17.

	1.3.1.3. Reduce the percentage of children using the emergency room as their usual source of primary care.	Data Sources: Hospital Discharge Data of 1998 from the California Office of Statewide Health Planning Department Methodology: Review change in emergency room utilization before and after Healthy Families Implementation. Progress Summary: Statewide, the number of children between the ages of 1 and 18 using emergency room in 1998 was 26,231. MRMIB is currently investigating alternative data sources for monitoring the changes in this measure. It is also accessing the utility of this measure as a predictor of the contribution the HFP has in lowering rates.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
1.3.2. Provide an application and enrollment process which is easy to understand and use.	1.3.2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.	Data Sources: Enrollment Contractors/Enrolled Entities Methodology: Review and survey of current materials. Progress Summary: See narrative on page 17.
1.3.3. Ensure that financial barriers do not keep families from enrolling their children.	1.3.3.1. Limit program costs to two percent of annual household income.	Data Sources: Internal Enrollment Data, program design data, survey data Methodology: Review and analysis. Progress Summary: See narrative on page 18.

1.3.4. Ensure the Participation of Community Based Organizations in Outreach/Education Activities.	1.3.4.1. Ensure that a variety of entities experienced in working with target populations are eligible for an application assistance fee.	Data Sources: MRMIB/DHS financial records Methodology: Summary of expenses for application assistance from 10/1/99 to 9/31/00. Progress Summary: See narrative on page 19.
	1.3.4.2. Ensure that a variety of entities experienced in working with target populations and have subcontracts have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Sources: Outreach and Education Contracts/Enrolled Entity Survey Methodology: Review contract listing. Progress Summary: See narrative on page 19.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
1.3.5. Provide a choice of health plans.	1.3.5.1. Provide each family with two or more health plan choices for their children.	Data Sources: Enrollment data from Healthy Families Program Administrative Vendor - Electronic Data Systems (EDS) Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Progress summary: See narrative on page 19.
1.3.6. Encourage the inclusion of traditional and safety net providers.	1.3.6.1. Increase the number of children enrolled who have access to a provider within their zip code.	Data Sources: Data from administrative vendor/provider locations from GeoAccess Methodology: Review change in penetration pre and post HFP implementation. Progress Summary: Approximately **3.3%** of total subscribers live in a zip code that has no provider.

	1.3.6.2. Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.	Data Sources: Health Plan Traditional & Safety Net Provider Report CPP Designations Methodology: Reports submitted by Healthy Families Participating health plans on the number of children who have a Traditional and Safety Net provider as their PCP. Progress Summary: See narrative on page 19.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED) cont'd		
1.3.7. Ensure that all children with significant health needs receive access to appropriate services.	1.3.7.1. Maintain or improve the percentage of children with services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 20.
	1.3.7.2. Ensure no break in coverage as they access specialized services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 20.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
1.3.8. Ensure health services purchases are accessible to enrolled children.	1.3.8.1. Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Currently being compiled. HEDIS measures for annual report period are not available until mid-year 2001.

	1.3.8.2 Achieve year to year improvements in the number of children who have had a child exam at appropriate interval.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Available mid-year 2001.
	1.3.8.3. Achieve year to year improvements in the number of children who have received immunizations by age 2 and age 13.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Not available at this time. HEDIS measures for annual report period are not available until mid-year 2001.
OTHER OBJECTIVES		
1.3.9. Strengthen and encourage employer - sponsored coverage to maximum extent possible.	Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs.	Data Sources: Application Data Methodology: Summarize responses from HFP applications. Numerator: Number of applicants that had coverage through an employer within the prior 90 day period Denominator: Total applicants Progress Summary: In order to prevent crowd-out, applicants to the Healthy Families Program and Medi-Cal for Children must answer questions about their previous health coverage. Data collected from the implementation of the Healthy Families Program indicates that 4.11% of successful applicants had coverage through an employer within the prior 90-day period. Of the applicants who indicated they had coverage within the prior 90 days, 60% indicated loss of employment, 12% had an employer who discontinued benefits to all employees, 7% cited end of COBRA coverage and the remainder indicated other reasons. These numbers indicate that crowd-out has not affected the HFP to any significant degree.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

MRMIB will conduct the *Healthy Families Children's Health Assessment Survey* over a three-year period, starting February 2001. The survey will track the changes in the physical, emotional, and social health of HFP subscribers and allow MRMIB to quantify the benefits of enrollment in the HFP.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program ' s performance. Please list attachments here.

<u>Narrative 1.3.1.1</u> Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.

While there has been a reduction in the total number of children in Medi-Cal between June 1999 and June 2000, there has been an increase in the number of children in both the Medicaid Expansion and the One Month Bridge to Healthy Families programs.

	June 1999	June 2000	Percent Change
Total Medicaid	2,672,348	2,584,015	-3.3%
Regular Medicaid	2,656,021	2,563,188	-3.5%
Medicaid Expansion	16,327	20,827	27.6%
One Month Bridge	1,677	2,968	75.7%

From: Healthy Families (CHIP) Medicaid Expansion, Regular Medicaid, and One Month Bridge Monthly Eligibles Later Updates to the Data for the CHIP Quarterly Statistical Reporting on HCFA-64.21E, HCFA-64EC, and HCFA-21E 10/30/00. Prepared by DHS Fiscal Forecasting and Data Management Branch.

The decrease in the overall percentage of Medi-Cal eligible children who are enrolled in Medi-Cal must be considered in light of the state's booming economy, where family incomes are increasing above the poverty levels of the Medi-Cal program. Although some of the children may have become ineligible for no cost Medi-Cal because of a combination of age and income (percent programs), they may have become eligible for the Healthy Families Program, thereby continuing health care coverage.

In comparison to the dramatic decrease in families eligible for CalWORKs cash grants, the Medi-Cal program has had only a slight decrease in the overall number of children enrolled. This maintenance of Medi-Cal enrollment of children can be attributable to the outreach efforts and the State's implementation of a number of changes in the Medi-Cal program. These efforts and changes have had a combined effect of making it easier for families and children to apply for Medi-Cal and stay on Medi-Cal.

The Department Health Services has allocated $17.9 million in fiscal years 1999-00 and 2000-01 to counties to conduct Section 1931(b) outreach activities. This includes outreach to families in aid code 38 to complete the redetermination process and to working families about the availability of Medi-Cal coverage, which is not linked with TANF (CalWORKs). On March 1, 2000, the income eligibility for the Section 1931(b) program was increased to 100 percent of poverty and the definition of deprivation was changed so that working parents with incomes below 100 percent of poverty would be eligible. The Department of Health Services sent notices to Medi-Cal eligible families notifying them of this change in program eligibility.

For the Healthy Families/Medi-Cal for Children program, the State has adopted a simplified, joint mail-in application. Effective July 1, 2000, the State eliminated the face-to-face interview for Medi-Cal. Effective October 1, 2000, the State has adopted the foster care federal option that continues Medi-Cal

coverage form age 18 to 21 for youth who transition out of foster care. Effective January 1, 2001, the State eliminated the quarterly status report and adopted 12-month continuous eligibility for children. Effective July 1, 2001, there will be changes in Medi-Cal eligibility criteria and procedures with regard to when eligibility is terminated and when circumstances change that affect eligibility.

Narrative 1.3.1.2: Reduce the percentage of uninsured children in target income families that have family income above no cost Medi-Cal

The estimated baseline number of uncovered low-income children eligible for the Healthy Families Program (SCHIP) as of 9/30/00 was 639,000. The total number of children ever enrolled from implementation to 9/30/99 was 403,995.

Denominator- HFP eligible baseline (see Question 4 on pages 6 and 7 for a detailed description)

D = New estimated number of uninsured children in target income families
= 639,000

Numerator- Actual number of uninsured children insured under HFP during the reporting period.
N = Actual number of uninsured children insured under HFP during reporting period.
= 331,507

Progress toward goal-Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal:

P =(N/D)= **331,507 / 639,00 = 52%**

This measure illustrates the relative speed of California's progress in meeting the goal. The progress California is making towards this goal has been consistent and has kept pace with the changes in the estimate of the target population. The HFP enrolled over **40,000** new children in the newly established **200%-250%** eligibility category.

Narrative 1.3.2.1: Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.

Applicants can receive enrollment instructions, a handbook and application in eleven languages. The joint application (Medi-Cal for Children and Healthy Families Program) is a simple user-friendly document with each question referenced and explained in detail. Color-coding is used to delineate areas and call attention to important facts.

A Certified Application Assistant (CAA) is available to assist families in completing the application. CAAs are community-based trained persons and are located throughout the state. Each CAA is affiliated with an Enrollment Entity (EE). Enrollment Entities are public and private based organizations such as clinics, schools, and businesses. EEs are paid an assistance fee ($50) for each successful application. This service is free to the applicant.

The Managed Risk Medical Insurance Board has a stand-alone website where program and application data are also available. The address is www.HealthyFamilies.ca.gov.

The toll Free HFP information line, 1-800-880-5305, was established and is administered by MRMIB's contract with the administrative vendor, EDS. Enrollment specialists offer HFP information, enrollment assistance and status, account maintenance and billing information to families.

A team of operators proficient in the eleven designated languages in which campaign materials are published staffs the line. The following table describes the frequency of calls by language:

Language	Program to Date	% of Total
English	688,321	57.11
Spanish	412,877	34.25
Cantonese	30,855	2.56
Korean	7,415	.62
Vietnamese	4,506	.37
Armenian	2,356	.20
Russian	960	.08
Cambodian	914	.08
Hmong	155	.01
Farsi	825	.07
Lao	123	.01

***Narrative 1.3.3.1:* Limit program costs to two percent of annual household income.**

California continues to make significant progress in limiting Healthy Families Program costs to two percent of annual household income. The following table represents the aggregate distribution of income and premiums for enrollees during the reporting period. The maximum weighted average program costs, based on the mix of actual program enrollees as a percent of income, was 1.6%.

This analysis assumes an average family size of four, 39% of subscribers receiving the $3/month discount for enrolling with a Community Provider Plan (please see narrative for 1.3.6.1 on the following page), and expending the maximum health co-payment of $250. The $250 co-payment equals 50 visits or prescriptions per year at $5 per visit.

Aggregate Income and Premium Statistics

Countable Income Level. Federal Poverty Level (FPL)	Percent mix of Subscribers	Average Annual Premium (assuming 39% take $3 discount)	Maximum Allowable Health Co-payments	Maximum Total Program Cost	Average Annual Income	Maximum Program Cost as a Percent of Income
Under 150%	43%	$150	$250	$400	$21,003	1.9%
Over 150%	57%	$197	$250	$447	$30,103	1.4%

Narrative 1.3.4: Ensure the Participation of Community Based Organizations in Outreach and Education Activities.

The community-based organizations are an integral part of the Healthy Families Program Outreach strategy. As of September 2000, 63% of applications received through the *Single Point of Entry* process were assisted by organizations that participated in the application assistance fee program. In addition, a total of $6 million was allocated to HF/MCC CBO outreach contracts in the state FY 99/00.

Narrative 1.3.5.1: Provide each family with two or more health plan choices for their children.

The Healthy Families Program offers a broad range of health plans for program subscribers. A total of 26 health plans participated in the program during the reporting period. Over **99%** of subscribers had a choice of at lease two health plans.

Narrative1.3.6.2: Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.

The MRMIB designed a traditional and safety net provider program that provides access to care in all areas of the state. As an incentive to include traditional and safety net providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan (CPP). Plans with the Community

Provider Plan designation are offered at a $3 discount per child per monthly premium discount. Traditional and safety net providers are available in all areas of the state, and all HFP subscribers have access.

Fourteen of 26 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Of all HFP subscribers, 39% are enrolled in a CPP and receive a $3 discount.

Narrative 1.3.7: Ensure that all children with significant health needs receive access to appropriate services:

Children enrolled in the HFP are referred to the California Children's Services (CCS) Program or the county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. As such, the numbers of children with special health care needs that are tracked by HFP are those children known by the plan and the county. Reports submitted by participating plans indicated that 925 children were referred to the CCS program and that 156 children were referred to county mental health during the 1999/00 State fiscal year. To facilitate the tracking of these children, the State has implemented two administrative systems that will be fully operational by December 31, 2000.

The State monitors access to services for children with special health care needs by holding routine meetings with health, dental and vision plans and the CCS and county mental health programs and through follow-up on complaints received from subscribers. The routine meetings with plans and the programs allow the State and plans to discuss any arising or foreseeable barriers to access, and way to eliminate these barriers. During the reporting period, brochures were developed for the CCS and county mental health programs to better educate families about the CCS and county mental health programs.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. ***If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.***

California did not offer family coverage.

2. ***How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?***

Number of adults	N/A
Number of children	N/A

3. ***How do you monitor cost-effectiveness of family coverage?***

N/A

2.2 Employer-sponsored insurance (ESI) buy-in:

N/A

1. ***If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).***

N/A. California did not have an employer sponsored buy-in program.

2. ***How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?***

Number of adults	N/A
Number of children	N/A

2.3 Crowd-out:

1. ***How do you define crowd-out in your SCHIP program?***

Crowd-out is defined as the substitution of employer-based coverage for publicly funded (e.g., Medicaid and SCHIP) coverage. It is also defined as employers dropping health

insurance coverage because public alternatives are available. Children who have had employer sponsored coverage 90 days prior to the date of application are not eligible for the HFP.

2. How do you monitor and measure whether crowd-out is occurring?

Crowd-out is monitored through the eligibility determination process and the collection of data. Applicants must answer questions about each child's previous health coverage. Children who received employer-based health coverage 90 days prior to application are not eligible for the HFP, unless they qualify for specific exemptions.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Data collected from the implementation of the HFP indicates that 4.11 percent of successful applicants had coverage through an employer within the prior 90-day period. The following reasons were provided as to why the children did not have coverage at the time of application or would no longer be covered on the effective date of enrollment.

- 2.47 percent stated their child(ren) would be uninsured due to loss of employment.
- .31 percent had an address change to where no coverage was available through the employer's plan.
- .48 percent had an employer who discontinued benefits to all employees.
- .28 percent cited the end of COBRA coverage.
- .57 percent listed other.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The crowd-out policies that were implemented through the eligibility determination process appear to have been successful. Applicants are required to report whether their children have had previous health insurance coverage. The applicants are also required to report the reasons why they do not have coverage at the time of application. The policies have worked to discourage substituting public coverage for private coverage. Based on the analysis of the current policies of crowd-out and these appear to have been effective.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The goal of the State's HFP/MCC Campaign is to use a combination of mass media education and local community-based outreach strategies to build broad-based public awareness of the availability of the State's children's health care coverage programs. All campaign components are

designed to work together to promote enrollments. The call to action for the multilingual advertising messages is to call the campaign's outreach toll-free number, 1-888-747-1222 for information and an application. There is a direct correlation between the media schedule and the call volume, with call volume reaching over 2,000 calls per day during active media weeks. During the state Fiscal year (FY) 2000-01, when callers were asked how they heard about the HFP/MCC, more than 35% of all callers to the toll-free line identified advertising. Additionally, toll-free line callers are advised about the availability of certified application assistants (CAA) and referrals are made to CAA's to help families enroll in the programs. As a result, more than 60% of all applications submitted are assisted. Community efforts are strengthened by the availability of multilingual television, radio and print media. School-based efforts, such as the school lunch program outreach activity, have also proved to be highly effective in promoting HFP/MCC and generating requests for applications and information about the programs.

Currently, the State is contracting for an independent review of the effectiveness of the community-based contractors outreach efforts and HFP/MCC enrollments. This report should be available in Spring 2001.

During state FY 2000-01, the Governor augmented the media budget by $10 million to educate and enroll the harder-to-reach and not yet enrolled families. Based on the findings of the public awareness survey and other independent research, the campaign has developed new advertising messages that speak more directly to families about eligibility ("working families qualify"); cost ("$4-9 month per child for Healthy Families and Medi-Cal is free"), and ease in applying ("short, easy, mail-in application," and "free local assistance is available"). These new ads are planned to be launched in January 2001.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

During FY 1999-2000 and FY 2000-01, the campaign conducted targeted media outreach to immigrant communities that are linguistically diverse. New campaign strategies and materials were developed and introduced to reach monolingual Latino and Asian communities. HFP/MCC outreach materials to target Latinos included two Spanish language fotonovelas; a radio novela; public service announcements utilizing trusted television personalities; and news articles in Spanish language papers. Three Asian language 60-second radio ads were produced in Chinese, Korean, Hmong and Vietnamese. At this time, no formal evaluation has been conducted; however, there has been marked increase in the numbers of in-language calls to the toll-free line as a result of these activities.

During 2001, the campaign will increase targeted media through non-traditional advertising mechanisms such as electronic billboards in convenience stores located in communities with high concentration of African American families. Additionally, the campaign will post campaign

messages on lunch trucks and in selected community clinics to reach more minorities.

3. Which methods best reached which populations? How have you measured effectiveness?

As stated in 2.4.1, the State's campaign is multi-faceted and utilizes the power of mass media along with the strength of the community based outreach through contractors and certified applicant assistants to reach and enroll eligible children in HFP and MCC. Taking into account the State's diverse communities, there will be a variety of "best methods". One of the products of the evaluation of the community-based contractors will be an identification of best practices that can be shared with other contractors.

2.5 Retention:

1. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

The HFP uses a customized printed Annual Eligibility Review (AER) package that the family reviews and returns with current income verification. This information is mailed 60 days prior to the anniversary date of the application. A reminder postcard is mailed and a courtesy telephone call is made 30 days prior to the AER due date.

At the time of the Annual Eligibility Review or when using the ***Add A New Child*** form if it is determined that the family income is too low for the Healthy Families Program and the applicant has given authorization, the application is forwarded to the county welfare departments (CWDs) to be evaluated for eligibility for no-cost Medi-Cal. This coordinated process ensures continuity of care and prevents the family from being required to complete a new application in order to receive no-cost Medi-Cal. Most CWDs are now utilizing a telephone and mail-in process to obtain any additional information to establish eligibility for Medi-Cal.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
___ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
___ Information campaigns
___ Simplification of re-enrollment process, please describe _____
_X_ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe:

HFP attempts two telephone calls to families who are disenrolled from the program to determine the reason for their disenrollment. If HFP is unable to reach the applicant by telephone, a postcard is sent to the applicant to request a reason for disenrollment. This

information is reported each month on the disenrollment telephone survey.

__X__ Other, please explain

HFP subscribers are disenrolled for non-payment of premiums 60 days after the last premium was received. Thirty days after premiums are not received, a billing statement is mailed to the applicant notifying them that they will be disenrolled in 30 days, and then 15 days before they are disenrolled a warning letter is mailed.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Children that are enrolled in Medi-Cal are "disenrolled" from no-cost Medi-Cal if they are found to be ineligible due to age or income. Although they may no longer be eligible for no-cost Medi-Cal, they would be eligible for the Medi-Cal share of cost program. In this sense, children are not truly "disenrolled" from Medi-Cal.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Following up with the applicant to ensure the Annual Eligibility Review materials have been received and returned, HFP ensures timely re-determination and continued eligibility.
The Annual Eligibility Review (AER) packet is sent to applicants 60 days prior to the children's anniversary date. The packet requests notification of changes in family status, size and updated income documentation within 30 days. The packet provides customized information for each family and notifies them of the response due date.

If the applicant does not respond after 30 days, a reminder postcard is mailed. This postcard notifies the applicant that they may lose coverage if they do not respond. A telephone number is provided for applicants to call.

After the postcard is mailed, the enrollment vendor attempts to call the HFP applicant by phone three times, at different times during the day, during the second thirty-day period.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

HFP attempts to contact applicants who are disenrolled for non-payment of premiums. This group represents approximately one-third (34%) of disenrollment. Of this group,

24% stated they had received other health insurance (13% Employer sponsored, 4.4% private insurance, and 6.6% no cost Medicaid).

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The HFP/MCC programs use a joint application. All applications are received at a Single Point of Entry (SPE) and screened for Medicaid income eligibility. SPE also documents the date applications are received and the date they are forwarded to the county welfare departments (CWD). The income and deduction verification is the same for children applying for Medicaid and/or HFP.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

SCHIP requests permission on the application and Annual Eligibility Review package to forward applications to the CWD if the child appears to be Medicaid eligible.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

There is a significant overlap in the managed care networks for HFP and for Medi-Cal. Of the 26 health plans offered by the HFP, 23 participate in the Medi-Cal program. Approximately 81% of HFP subscribers are enrolled in plans that participate in both programs.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Overall, approximately one third (34%) of all subscribers were disenrolled due to non-payment of premiums. Each month the State attempts to contact these disenrolled subscribers to determine why they did not pay the monthly premium. Of this non-payment group, the majority said they had received other health insurance

During the 2000 FFY, the Healthy Families Program implemented a "sponsorship" program, which allows sponsors to pay premiums on behalf of families.

***2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health service under SCHIP? If so, what have you found*?**

There are many services that are provided in the Healthy Families Program that do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services are provided without co-payment. Co-payments are not required for services provided to children through the California Children's Services Program and the county mental health departments to the children who are seriously emotionally disturbed (SED).

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

MRMIB obtains information on quality of care through health and dental plan reporting requirements and subscriber surveys. Data on the quality of care delivered during FFY 1999 is currently being collected and will be available during the first quarter of 2001.

The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets
Fact Sheets are submitted by each health, dental and vision plan interested in participating in the Healthy Families Program. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports
Each year, health and dental plans are required to submit quality of care reports based on HEDIS and a 120-day health (and dental) assessment measure. The HEDIS reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. The current data reflects the calendar year 1999. Data collected from the health and dental plans
will be reported in the first quarter of calendar year 2001 on a program wide basis, with specific plan reporting for calendar year 2000 anticipated in the fourth quarter 2001.

California Children Services (CCS) and Mental Health Referral Reports
The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to the CCS and county mental health services. Plans are required to report on a quarterly basis the number of children referred to these services. The numbers reported by plans will be compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services and Group Needs Assessment Reports
These reports allow staff to monitor how special needs of HFP subscribers related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans will provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

The Group Needs Assessment Report will identify the unique perspectives of subscriber based on their cultural beliefs. Participating plans are required to conduct an assessment of their subscribers to determine:

- Health-related behaviors and practices
- Risk for disease, health problems and conditions
- Knowledge, attitudes, beliefs and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs and practices related to health risk
- Perceived health, health care and health education needs and expectations
- Cultural beliefs and practices to alternative medicine

The assessment must also include an evaluation of community resources for providing health education and cultural and linguistic services and the adequacy of the network. Based on the results of the assessment, each plan is required to develop a program to address the needs identified in the group needs assessment. Participating plans will submit their first group needs assessment reports in June 2001.

Welcome Calls
EDS, the enrollment vendor for the HFP, makes welcome calls to families of each subscriber when they first enroll. These calls, which are made between the 10th and the 20th day of enrollment, allow staff to monitor whether subscribers are receiving their identification cards, and their Evidence of Coverage booklets as required by the contract.

Member Surveys

MRMIB uses two member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. The comparison of disenrollment trends and results from the disenrollment surveys provide another tool for monitoring plan performance.

The second survey, a consumer satisfaction survey, was conducted in the Fall of 2000. The survey was conducted in five languages (English, Spanish, Chinese, Korean, Vietnamese) and was based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0). Responses from the survey will provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health plans and overall health care.

Subscriber Complaints

MRMIB receives direct inquiries and complaints from HFP applicants. Ninety percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquires and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

See Question 1 on the previous page.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

A system is in place to review quality of care, as measured through the currently available quality measures, by certain demographic variables. These variables include age, language, ethnicity, and location. This system will provide the ability to identify quality-related issues (e.g., disparities in immunization rates, consumer satisfaction, etc.) that may arise with any demographic group represented in the program.

SECTION 3. SUCCESSES AND BARRIERS

1. Eligibility and Enrollment

The revised joint mail-in application and the *Single Point of Entry* (implemented April 1999) continued to improve the eligibility determination process. The application was revised to included an application tracking number (bar code) which improves tracking and payments to Certified Application Assistants. The *Single Point of Entry* has significantly improved the screening for no-cost Medi-Cal in a consistent and uniform manner and has provided an efficient system to forward applications to county welfare departments.

The continued posting of enrollment, disenrollment, and Single Point of Entry information on the MRMIB website has been a valuable tool for community-based organizations, local governments and other interested parties who are interested in evaluating the number of children enrolled in their county.

2. Outreach

The Medi-Cal for Children and Healthy Families Program (MCC/HFP) Outreach and Education Campaign has been successful in accessing hard to reach populations, minorities, and rural areas. Indicators of the campaign's success in reaching targeted populations include:

- Continued enrollment growth in the HFP
- 156,000 phone calls to the campaign's toll-free line for information and referral service.
- 125,000 applications and handbooks mailed out between July 1, 1999 and January 31, 2000.
- 35,000 requests for applications as a result of school outreach efforts.
- Funds to continue reimbursing Certified Application Assistants for enrolling children in MCC/HFP.
- Continue $6 million funding to local CBOs through contracts to conduct local outreach
- Increase in efforts to heighten public awareness through a variety of activities including celebrity endorsers, sponsorship promotions and school outreach among Latino, African-Americans, and other communities.

3. Retention/disenrollment

This area of program administration is the focus on ongoing management review. California is working with other states to identify best practices and barriers to retention. Activities that appear successful in addressing retention and disenrollment include:

- Courtesy calls placed 30 days prior to the anniversary date to confirm receipt of the Annual Eligibility Review package and to encourage timely submissions.
- Reminder post card mailed 30 days prior to the anniversary date to remind applicants to send in their Annual Eligibility Review Package.

- Telephone surveys of families who are disenrolled for non-payment of premium to determine the reason they did not pay.
- Ongoing collaboration with Community Based Organizations, CAAs and contracted plan partners to develop retention strategies.
- Use of revise billing statements that provide the applicant a 30-day, 45 day, and 60 day notice when a payment has not been received. The notice includes information about making cash payments to Rite Aid stores to ensure timely payments.
- Authorization request included on the Add A Child Forms, Annual Eligibility Forms and applications to permit the program to forward applicant information to Medi-Cal. Authorization requests are also included in notification letters to applicants who did not meet the income eligibility criteria for Healthy Families and who may qualify for Medi-Cal, and who did not initially authorize the program to forward their information to Medi-Cal.

4. Benefit structure

The dental benefits appear to be one of the more popular aspects of the program. Feedback from the public indicates that dental benefits have attracted members to the program. Data provided by the largest dental plan participating in the program showed that 80% of the children enrolled in that plan had received a dental service. Of the services provided, 72% were for preventative and restorative care.

5. Cost-sharing

Premiums do not appear to present a barrier to families in the program. Of the applicants who were disenrolled for non-payment of premium and were successfully contacted (28 percent of 34 percent) only 15.2 percent of the 28 percent said they could not afford the premium. This represents approximately 5 percent of all families who disenroll from the program.

6. Delivery systems

The HFP has employed successful approaches to improving delivery of health, dental and vision services:

- An incentive to include Traditional and Safety Net providers in health plan networks has been a successful tool in allowing subscribers the option of choosing plans that offer the T&SN providers (39% of total subscribers).
- Providing coverage in the rural areas continues to present a challenge. To meet the challenge, California implemented a Rural Health Demonstration Project. This project provides contract enhancements to health, dental, and vision plans participating in the program to expand access of services to rural areas. The Rural Health Demonstration Project has been a successful vehicle for developing partnerships between rural providers and private health and dental plans. These partnerships and the augmented funding have improved access in rural areas and to special populations. Each project that was awarded was reviewed. Data regarding these reviews will be available in 2001.

- The HFP Internet website, which provides network information including physicians, language, gender and specialty, promotes choice for families.

7. Coordination with other programs

Areas of coordination between the Healthy Families Program and other programs that have been successful include:

- The joint application and identical eligibility standards for HFP and MCC make it easier for families and CAAs to complete applications.
- Building on existing programs such as CCS guarantees continuity of care with plans participating in both programs (via MOU), families with children in both can have a single network.
- Development of a common set of responsibilities via MOUs provided the foundation for establishing necessary relationships between the plans and CCS/County Mental Health organizations.
- Early coordination of services between the state programs, regular meetings with plans, local program staff and designated liaisons for each involved entity proved valuable.

8. Crowd-out

Crowd-out under the HFP/MCC has not been identified in any significant degree.

9. Other

NA.

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 ***Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.***

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	$250,281,382	$456,804,693	$797,184,980
per member/per month rate X # of eligibles			
Fee for Service	$21,396,691	$20,410,947	$25,653,561
Total Benefit Costs	$271,678,073	$477,215,640	$822,838,541
(Offsetting beneficiary cost sharing payments)	-$17,667,790	-$31,065,318	-$63,276,352
Net Benefit Costs	$254,010,283	$446,150,322	$759,562,189
Administration Costs			
Personnel			
General administration	$25,616,483	$38,627,435	$53,339,913
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	$2,606,882	$10,729,300	$16,711,113
Other			
Total Administration Costs	$28,223,365	$49,356,735	$70,051,026
10% Administrative Cost Ceiling	$28,223,365	$49,572,258	$84,395,799
Federal Share (multiplied by enhanced FMAP rate)	$186,754,005	$327,034,658	$547,544,723
State Share	$95,479,643	$168,472,399	$282,068,492
TOTAL PROGRAM COSTS	**$282,233,648**	**$495,507,057**	**$829,613,215**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_____ State appropriations
___X___ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

4.4 Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 *To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)*

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	Medical for Children	Healthy Families Program
Provides presumptive eligibility for children	___X___No _____Yes, for whom and how long?	___X___No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___Yes, for whom and how long? 3 months	___X___No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff ___X___Other *(specify)* County eligibility offices	_____State Medicaid eligibility staff ___X___Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months ___5___(Based on individuals who were eligible at any time during the fiscal year.)	Specify months ___11___ (The average length of stay is increasing each month. The program is still in its start-up phase.)
Has joint application for Medicaid and SCHIP	_____No ___X___Yes	_____No ___X___Yes
Has a mail-in application	_____No ___X___Yes	_____No ___X___Yes
Can apply for program over phone	___X___No _____Yes	___X___No _____Yes
Can apply for program over internet	___X___No (The joint application can be downloaded _____Yes from the internet.)	___X___No _____Yes

Requires face-to-face interview during initial application	___X__ No _____ Yes	___X__ No _____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	___X__ No _____ Yes, specify number of months _____ What exemptions do you provide?	_____ No ___X___ Yes, specify number of months 3 What exemptions do you provide? See page 37.
Provides period of continuous coverage <u>regardless of income changes</u>	_____ No ___x__ Yes, specify number of months ____12____ Explain circumstances when a child would lose eligibility during the time period	_____ No ___X__ Yes, specify number of months 12_____ Explain circumstances when a child would lose eligibility during the time period *19 year old; by request; nonpayment of premiums.*
Imposes premiums or enrollment fees	__X___ No _____ Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____ ___	_____ No ___X__ Yes, how much? $4.00 to $9.00 per child. Maximum $27.00 per month for all children in the family. _____ Who Can Pay? __X_ Employer (with specified exceptions) __X_ Family __X_ Absent parent __X_ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	___X___ No ____ Yes	_____ No ___X__ Yes
Provides preprinted redetermination process	___X___ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No ___X___ Yes, form sent to family with their information and: __X_ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

Exemptions are given to families which children who have had employer-sponsored coverage if they meet one of the following criteria:

- The person or parent providing health coverage lost a job or changed jobs
- The family moved into an area where employer-sponsored coverage is not available
- The employer discontinued health benefits to all employees
- Health coverage was provided under a federal Consolidated Omnibus Budget Reconciliation Act (COBRA) policy and the COBRA coverage ended
- The child reached the maximum coverage of benefits allowed in the current insurance in which the child is enrolled

5.2 Please explain how the redetermination process differs from the initial application process.

The process is simpler. Personalized forms are sent to families and only current income documentation needed.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	____% of FPL for children under 19 ____% of FPL for children aged ____% of FPL for children aged
Medicaid SCHIP Expansion	0-200% of FPL for children aged 0-1 100%-133% of FPL for children aged 1-6 <100 % of FPL for children aged 7-18
State-Designed SCHIP Program	200% - 250% of FPL for children aged 0-1 133% - 250% of FPL for children aged 1-6 100% - 250% of FPL for children aged 7-18

6.2 As of September 30, 2000, what types and amounts of disregards and deductions does each program use to arrive at total countable income? Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter NA.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$	$	$
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$	$	$
Paid	$	$	$
Child care expenses	$	$	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 ***For each program, do you use an asset test?***

Title XIX Poverty-related Groups	__X__No	____Yes, specify countable or allowable level of asset test
Medicaid SCHIP Expansion program	_X_ No	____Yes, specify countable or allowable level of asset test
State-Designed SCHIP program	_X_ No	____Yes, specify countable or allowable level of asset test
Other SCHIP program: _AIM_	_X_ No	____Yes, specify countable or allowable level of asset test

6.4 ***Have any of the eligibility rules changed since September 30, 2000?*** ___ Yes __X__ No

The state is going to implement a 12-month continuous enrollment for children on Medi-Cal effective January 1, 2001.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 ***What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.***

1. ***Family coverage:***
   On December 19, 2000 California submitted a request for a waiver to extend coverage to uninsured parents. Coverage would be extended to parents of enrolled children in families with incomes between 100 and 200 % of fpl and parents with incomes below 100% who do not qualify for Medicaid.

2. ***Employer sponsored insurance buy-in:*** NC.

3. ***1115 waiver***: (See answer to question #1)

4. ***Eligibility including presumptive and continuous eligibility:*** NC.

5. ***Outreach:***
   The campaign is being augmented to place increased emphasis on school-based outreach strategies.

6. ***Enrollment/redetermination process:***

   Effective July 1, 2001, there will be changes in Medi-Cal eligibility criteria and procedures with regard to when eligibility is terminated and when circumstances change that affect eligibility.

7. ***Contracting:*** NC.

8. ***Other***

Appendix

Eligibility Determination Process

The eligibility determination process starts with a simple four page document, which provides initial participant data. To document income eligibility, applicants provide pay stubs, a signed letter from employer verifying income, federal tax return or current profit and loss statement with the application. A completed application takes 10 days to determine eligibility, which includes a single point of entry screening for no-cost Medi-Cal of four days. If the applicant is Healthy Families eligible, an additional 10 days is required by the health plan to process, enroll, and provide the subscriber with the required ID cards and enrollment packets. The Program Administrative Vendor uses "Eligibility Enrollment Specialists" to review and approve the initial eligibility and application. Approval is provided when all eligibility requirements are satisfied. A welcome letter is sent after approval and a “welcome call” is made 10 to 20 days from the effective date of enrollment.

Eligibility/Redetermination Process

Continuous eligibility for the Healthy Families Program (HFP) is for 12 months. Each year an annual eligibility review (AER) is done to confirm a member's continuing qualification for the HFP. AER is a two-page customized package requesting the applicant review and update family composition changes and provide income. Just like the initial application process, income documentation must accompany the AER package. If the applicant responds in a timely manner, there is no break in coverage. Adding a child will change the family’s anniversary date to the date the last child was enrolled. The program administrative vendor utilizes a separate group of eligibility specialists to review and approve AER packets.

Coordination

Medi-Cal

California recognizes that coordination between HFP and Medi-Cal is an important factor in ensuring that low-income families have access to continuous health care coverage. Both programs rely on income, family size and income deductions to determine a child's eligibility.

A *joint application* form for the Healthy Families Program and Medi-Cal has been successfully implemented.

A "*single point of entry*" receives and screens all mail-in applications.

When children served by Medi-Cal experience increased family incomes, which would cause them to no longer be eligible for no cost Medi-Cal coverage, they are granted an additional one month of eligibility to give them adequate time to apply for and enroll in the Healthy Families Program.

Implementing a resource disregard for children in the Medi-Cal federal poverty level programs and utilization of income deductions in the Healthy Families Program further facilitates coordination between Medi-Cal and the Healthy Families Program. California also closely

coordinates with programs offering specialized services provided by the California Children's Services Program and the County Mental Health Program.

Child Health Disability Program

Children come to Healthy Families through a "*gateway program*" called CHDP. CHDP providers offer early medical screens and immunizations (following EPSDT guidelines) for children under 200% of FPL and perform a critical eligibility screening and referral function to HFP. When children receive services from a CHDP provider, they are either referred to Medi-Cal or to the Healthy Families Program. Should follow-up treatments be required for a condition identified in the CHDP screen, Medi-Cal or the Healthy Families Program (depending on which program the child ultimately enrolls in) will cover the cost of care provided to children for 90 days prior to enrollment.

California Children Services

The CCS program has been integrated into the HFP benefit design, CCS provides case management and treatment for chronic, serious, and complex physically handicapping conditions. Children receiving such services continue to have their primary health needs served through the Healthy Families Program's health, dental and vision plans. Data reported by participating plans showed that 925 referrals to CCS were made during SFY 1999/00.

County Mental Health Departments

Children with serious emotional disturbances (estimated at between three to five percent of the general population) are referred by the HFP participating health plans to the county mental health program for treatment. The referral is made, pursuant to a Memorandum of Understanding (MOU) between the two organizations, for treatment of serious emotional disturbances. Data reporting by participating health plans showed that 156 referrals to county mental health departments were made referrals during SFY 1999/00.

The required MOU formalizes this important arrangement. The county mental health program coordinates the delivery of mental health and other health services with the health plan for those children who meet the criteria of serious emotional disturbance. County mental health programs provide mental health treatment services directly or through contracts with private organizations and individual providers.

Rural Health

For the rural areas, California has initiated a Rural Health Demonstration Project. This project is designed to increase the number of providers or enhance the access to providers in rural areas of the state. As of July 1998, the RHDP has funded 86 different projects. Since July 1998, $12 million has been encumbered; $6 million for projects that enhance access to care for children with migrant and seasonal worker parents and $6 million for projects that increase the number of providers in a geographic area. This funding has been allocated to projects throughout California concentrating on clinics in rural counties that are geographically isolated, or counties with high concentrations of special populations that may be linguistically isolated or otherwise not afforded access to health, dental or vision insurance.

In addition to the RHDP, MRMIB has made available a *Rural Health Plan combination* designated as a statewide plan choice providing access to migrant and seasonal farm workers, native Americans, and children of families working in the fishing and forestry industry. The plan is a combination of health, dental and vision insurance. Healthy Families subscribers who identify themselves as one of the above groups can enroll in this program and receive access to services anywhere in the state, regardless of their county of residence, as long as they remain California residents.

Projects throughout the State range in complexity; from increasing the normal business hours to provide services in the evenings and weekends to TeleMedicine projects and mobile dental clinics.

The types of projects funded through MRMIB differ from county to county depending on local needs. The goal is to fund projects that satisfy the needs and best serve the interests of the HFP participants.